U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 November 2004

CASE NO: 2003-BLA-192

In the Matter of:

AARON D. BOLEN
Claimant

v.

AMIGO SMOKELESS COAL COMPANY;
SEWELL MINING ASSOCIATES;
McDORMAN MINING, INC., PARTNER
IN SEWELL MINING ASSOCIATES;
RICHARD McDORMAN, PARTNER
IN SEWELL MINING ASSOCIATES
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party in Interest

APPEARANCES:

Aaron D. Bolen
Pro se

Mary Rich Maloy, Esq.
For the Employer

Before: DANIEL L. LELAND
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* In accordance with the Act and the pertinent regulations, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under this Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as black lung.

A formal hearing was held in Beckley, West Virginia on June 22, 2004 at which all parties were afforded full opportunity to present evidence and argument, as provided in the Act and the regulations found in Title 20 Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title. At the hearing, Director's exhibits (DX) 1-72 and Claimant's exhibit (CX) 1 were admitted into evidence.

ISSUES

I. Existence of pneumoconiosis.

II. Causal relationship between pneumoconiosis and coal mine employment.

III. Total disability.

IV. Causation of total disability.

V. Responsible operator

VI. Length of employment

FINDINGS OF FACT AND CONCLUSIONS OF LAW[1]

Procedural History

Aaron D. Bolen (Claimant or miner) filed the present claim for benefits on July 10, 1997. (DX 1). The claim was denied by the district director on December 18, 1997, and a formal hearing was requested on January 8, 1998. (DX 17, 18). Administrative Law Judge Edward Miller remanded the claim to the district director to investigate the issue of responsible operator on April 15, 1999. (DX 52). The district director again denied the claim and made specific findings of fact regarding the responsible operator investigation on February 4, 2003. (DX 67). The claim was referred to the Office of Administrative Law Judges on May 7, 2003. (DX 72).

Background

Claimant was born on July 6, 1944. (DX 1), and has one dependent, his wife, Julia. (TR 7). Employer has stipulated to five years of coal mine employment. (TR 7). Claimant claims twenty-six years of coal mine employment, from 1961 until his retirement in 1995. (TR 13-18). Claimant testified that his last coal mine employment was as a general inside

[1] The following abbreviations have been used in this decision and order: TR = transcript of hearing; BCR = board-certified radiologist; and B = b-reader.

laborer and part owner. (TR 18). The miner hung curtain, cut and set timbers, worked up in the face, and did any other tasks as needed. (TR 18). When asked how the miner would characterize the work which he had performed, he stated that "some of it was heavy labor and some- mostly moderate labor" and the heaviest thing he had to lift was between one hundred and one hundred and twenty five pounds. (TR 18-19).

Claimant has been prescribed medications for breathing since 1993, including a nebulizer and inhalers. (TR 20). Claimant stopped working due to breathing difficulties and leg tremors in 1995. (TR 19). Claimant smoked from age fifteen or sixteen to 1994 and consumed one third of a pack of cigarettes a day. (TR 21).

Medical Evidence

Chest x-rays[2]

Exhibit	X-ray Date	Physician	Interpretation
CX 1	2/27/91	Speiden, BCR, B	0/1, t/p
EX 1	5/14/96	Wheeler, BCR, B	No evidence of pneumoconiosis
EX 1	5/14/96	Scott, BCR, B	No evidence of pneumoconiosis
DX 13	8/11/97	Patel, BCR, B	No evidence of pneumoconiosis opacities
DX 14	8/11/97	Cole, BCR, B	No evidence of pneumoconiosis
DX 30	8/11/97	Wheeler, BCR, B	No evidence of pneumoconiosis
DX 30	8/11/97	Scott, BCR, B	No evidence of pneumoconiosis
DX 31	3/20/98	Ranavaya, B	1/0, p/q
DX 39	3/20/98	Sargent, BCR, B	No evidence of pneumoconiosis
DX 40	3/20/98	Cole, BCR, B	No evidence of pneumoconiosis
DX 32	4/20/98	Castle, B	No evidence of pneumoconiosis
DX 33	4/20/98	Wiot, BCR, B	No evidence of pneumoconiosis
DX 33	4/20/98	Spitz, BCR, B	No evidence of pneumoconiosis
DX 36	4/20/98	Shipley, BCR, B	No evidence of pneumoconiosis
DX 38	4/20/98	Fino, B	0/0
DX 60	4/20/98	Wheeler, BCR, B	No evidence of pneumoconiosis
DX 60	4/20/98	Scott, BCR, B	No evidence of pneumoconiosis
DX 62	4/20/98	Kim, BCR, B	No evidence of pneumoconiosis
CX 1	4/29/98	Ranavaya, B	1/1, p/p
CX 1	8/26/98	Jabour	1/1, p/p
EX 1	12/21/99	Wheeler, BCR, B	No evidence of pneumoconiosis
EX 1	12/21/99	Scott, BCR, B	No evidence of pneumoconiosis

2 Three x-rays were mentioned in Dr. Jabour's report found at CX1, but the identities of the readers or the classification system utilized were not revealed. For the purpose of providing an accurate summary, the x-rays omitted from the above chart are: an 8/12/97 "pleural thickening classifiable as pneumoconiosis" x-ray; an 9/19/97 "compatible with pneumoconiosis" x-ray; and an 8/11/97 "not compatible with pneumoconiosis" x-ray. Additionally, within the miner's hospitalization records on March 11, 1997, an -ray was read by Dr. Porowski as "mild hyperaeration, no change from earlier examination," and no interpretation for pneumoconiosis was made on the film of record.

Pulmonary Function Studies

Exhibit	Date	Height	Age	FEV1	FVC	MVV
CX 1	5/14/96	64"	51	1.78	1.93	69
DX 8	9/3/96	63.8"	52	2.00	2.50	47
DX 10	8/11/97	64"	53	1.76 1.99*	2.40 2.59*	55 65
DX 31	3/20/98	64"	53	1.88 2.18*	2.38 2.78*	43.9 72.9
DX 32	4/20/98	63"	53	2.14 2.13*	2.80 2.85*	73 87*
CX 1	8/26/98	64"**	54	1.69 1.95*	2.23 2.46*	--- ---
CX 1	12/21/99	64"	55	1.83 1.98*	2.73 2.79*	39 52*

*results post-bronchodilator
**Test as documented in Dr. Jabour's 8/26/98 report. No height was provided and therefore the results were measured under the miner's highest reported height.

Blood Gas Studies

Exhibit	Date	PCO2	PO2
CX 1	12/27/96**	37	58.5
DX 12	8/11/97	35 34*	78 88*
DX 31	3/20/98	33.2	78.2
DX 32	4/20/98	36.7	74

*exercise values
**as reported on the 12/31/96 discharge summary from Columbia-Raleigh General Hospital

Medical Reports

The West Virginia Occupational Pneumoconiosis Board found the miner to suffer from pneumoconiosis on May 15, 1996. (CX 1). The board found pleural thickening on miner's x-ray and scattered small opacities. The board opined that miner was not impaired, but the miner was later awarded a twenty-five percent permanent disability award.

Dr. Donald L. Rasmussen, who is board-certified in internal medicine and a pulmonary specialist, examined Claimant on September 3, 1996 and August 11, 1997 (DX 8, 11). Dr. Rasmussen's 1996 report notes a five to six year shortness of breath history with exertion, a current chronic productive cough, occasional paroxysmal nocturnal dyspnea, and shortness of breath after one flight of stairs. The miner worked twenty-six years, and his last coal mine job was as a section foreman which involved the heavy labor of rock dusting, shoveling, walking, and loading. Claimant used Aerobid & Maxair Inhalers and smoked a half a pack of cigarettes a day. Dr. Rasmussen diagnosed pneumoconiosis and asbestos pleural disease due to coal dust

exposure based on a 0/1, t/p x-ray, and found the miner twenty percent disabled due to pneumoconiosis based on a mild pulmonary insufficiency. Dr. Rasmussen again examined Claimant on August 11, 1997. The miner's employment history was again documented and notably the miner's last job as a section foreman included carrying a fifty-pound rock dust bags two hundred feet. The miner had a family history of heart disease, hypertension, pneumoconiosis, and emphysema. Claimant's personal history included attacks of wheezing, heart problems, and high blood pressure. Claimant smoked a half a pack of cigarettes a day from 1960 to 1996. The miner's current complaints were morning sputum and cough, wheezing, dyspnea with exertion, chest pain with deep breathing, three pillow orthopnea, and general poor sleep. Dr. Rasmussen heard moderately reduced breath sounds, but no rales, rhonchi or wheezing during the examination. Dr. Rasmussen diagnosed chronic obstructive pulmonary disease caused by smoking and coal dust exposure and non-occupational sleep apnea. Ventilatory studies showed a minimal partially reversible restrictive and obstructive impairment. Dr. Rasmussen opined that the miner suffered an overall minimal to moderate loss of respiratory function, and due to the miner's significant loss of lung function, he is unable to perform his last coal mine employment. Coal dust exposure was determined to be a contributing factor to the miner's disability.

Dr. Mohammad I. Ranavaya examined the miner on March 20, 1998. (DX 31). Claimant's chief complaints were ten years of exertional dyspnea that limited the miner to walking twenty-five feet on an incline, one hundred feet on a level surface, and a maximum of ten steps on a flight of stairs. The miner's smoking history noted a half a pack of cigarettes a day from 1981 to 1996. Claimant was prescribed Maxair and Proventil inhalers for his breathing problems. On physical examination a minimally prolonged expiration phase with a few scattered expiratory wheezes were heard. The pulmonary function studies showed a restrictive ventilatory defect and the blood gas studies revealed mild hypoxemia at rest. Dr. Ranavaya found that it was medically reasonable to conclude that the miner suffered from pneumoconiosis based on a 1/0, p/s x-ray and twenty-six years of occupational exposure to coal dust. Dr. Ranavaya found the miner to be totally disabled based on ventilatory studies and blood gas tests that showed a moderate pulmonary impairment which would prevent the miner from performing the heavy labor of his last coal mine employment as a section foreman.

Dr. E. Rhett Jabour, a pulmonary specialist, examined the miner on August 14, 1998. (CX 1). A smoking history of a third of a pack of cigarettes a day for twenty years was disclosed. Claimant was short of breath after walking one level city block, and sometimes suffered chest pain with exertion on both sides of his chest, which lasted two to three minutes. On examination, the miner's breath sounds were clear but diminished and the miner stated that strong odors and the like did not cause shortness of breath although hairspray sometimes made him choke. Testing was performed on the miner, including pulmonary function studies that revealed a moderately severe obstructive lung disease with air trapping, which had significant improvement with a bronchodilator. Mildly reduced diffusion capacity constant with airways hyper-reactivity was also noted. The chest x-ray was read as 1/0, p/s. Dr. Jabour opined that the miner suffered from a mild pulmonary impairment that was caused, at least in part, by coal dust exposure based on all previous medical records, work history, smoking history, and all testing.[3]

[3] Counsel for employer filed a Motion to Strike the x-ray dated 8/14/98 due to its destruction. This motion has been denied.

He deemed the miner to be twenty percent disabled, but also stated that the miner's respiratory impairment would preclude him from performing his last coal mine job. Finally, Dr. Jabour notes that there is x-ray evidence of pneumoconiosis at least to a mild degree and pleural thickening due to pneumoconiosis and possible exposure to asbestos.

Dr. Gregory J. Fino, a board-certified pulmonologist, conducted a review of the medical record on September 25, 1998. (DX 38). Dr. Fino found many of the pulmonary function tests invalid. Dr. Fino opined that the September 3, 1996 study was invalid due to flow, the August 11, 1997 study was invalid due to poor effort, and the June 16, 1998 study was also invalid because the MVV underestimates the miner's true lung function. Dr. Fino opined that the miner did not suffer from pneumoconiosis or a respiratory impairment, and that the miner was not disabled. His opinion was based on the majority of x-ray interpretations being negative for pneumoconiosis, his own interpretations of the x-ray, and the lack of ventilatory impairment demonstrated by the pulmonary function studies and blood gas studies. Dr. Fino issued a supplemental report on August 9, 2004 where he reiterated his prior conclusions and found that if the miner had pleural thickening, it was unrelated to coal dust exposure or coal mine employment.

Dr. James R. Castle, a board-certified pulmonologist, examined the miner on April 20, 1998. (DX 32). Claimant suffered shortness of breath walking one flight of stairs or walking one hundred feet on a level surface. A productive cough in the morning and wheezing were the miner's complaints. Occupational exposure to asbestos was noted for a two-week period in the 1960s, as well as twenty-six years of coal mine employment. The physical examination showed no chest abnormalities, and the x-ray produced no evidence of pneumoconiosis, but some pleural thickening deemed not consistent with pneumoconiosis was present. The pulmonary function studies demonstrated a mild airway obstruction without restriction or diffusion, and the miner had a normal carboxyhemoglobin level. Dr. Castle opined that the pleural thickening evidenced in the x-ray could be asbestos related, but that the miner suffered from asthmatic bronchitis which was smoking induced. A mild airway obstruction has resulted, but the miner retained the respiratory capacity to perform his last coal mine employment. Dr. Castle further noted that if the miner suffered a disability it was not respiratory in nature, but due to obesity and hypertension. Dr. Castle then was deposed on April 12, 1999. (DX 55). Dr. Castle discussed his earlier diagnosis and stated that the pleural thickness found on the miner's x-ray could be either asbestos related pleural plaque or subpleural fat, but then said no evidence of asbestosis was present. He also stated that the pulmonary function studies performed on September 3, 1996 and August 11, 1997 did not have lung volumes tested or showed restrictive lung disease. These tests could not be properly used to diagnose restrictive impairment because a forced vital capacity measurement would be required when any degree of obstruction is present. Dr. Castle then opined that no restrictive impairment was present based on the valid pulmonary function studies. Additionally, the miner was found to have the capacity to perform his last coal mine employment and that he did not suffer from a respiratory impairment caused by coal dust exposure. Finally, in a supplemental report issued on August 18, 2004 in which he reviewed all medical evidence of record, Dr. Castle opined that Claimant did not suffer from pneumoconiosis and retained the respiratory capacity to perform his last coal mine employment. (EX 5).

Dr. Robert G. Loudon, who is a pulmonary specialist, reviewed the medical evidence of record and issued a report on February 27, 1999. (DX 47). Dr. Louden found insufficient objective evidence to justify a diagnosis of pneumoconiosis, but found a mild pulmonary impairment which was obstructive in nature. Due to the reversibility of the obstructive impairment, Dr. Loudon stated that it could not be due to pneumoconiosis. Dr. Loudon opined that the miner is disabled due to his reversible chronic airflow obstruction, but this disability was not caused by pneumoconiosis or coal dust exposure. Dr. Loudon was deposed on May 5, 1997. (DX 57). Dr. Loudon explained that the miner was significantly overweight which can affect the miner's chest x-ray interpretations. The x-rays, however, do not offer any evidence of pneumoconiosis. Claimant does suffer from a minimal to mild airflow obstruction which is compatible with obesity and smoking. Again, Dr. Loudon found that the miner was not totally disabled, and did not suffer from a coal dust related pulmonary disease.

Dr. Thomas M. Jarboe, who is board-certified in internal medicine and is a pulmonary specialist, reviewed evidence of the record and issued a report on January 15, 1999. (DX 45). Dr. Jarboe opined that the objective evidence was not sufficient to support a diagnosis of pneumoconiosis. The miner suffered from bronchial asthma due to his reports of environmental irritants causing greater distress, and the improved ventilatory studies which cannot occur with coal dust exposure related diseases. Claimant suffered from a mild respiratory impairment based on Dr. Castle's studies, but the variations over time prove that the impairment is not caused by coal dust exposure. The objective studies do not support the presence of respiratory disability, and the miner retained "functional capacity to perform last coal mine employment in a dust free environment." Dr. Jarboe issued a supplemental report on August 11, 2004. (EX 2). Again he reiterated that the x-ray evidence does not support a diagnosis of pneumoconiosis and the pulmonary function studies do not support a diagnosis of a coal dust-induced lung disease. The miner's mild ventilatory impairment was caused by smoking and bronchial asthma, and Claimant retained the capacity to perform his last coal mine employment.[4]

Dr. W.K.C. Morgan, who is a pulmonary specialist, reviewed the record and issued a report on January 29, 1999. (DX 46). Dr. Morgan opined that no significant pulmonary impairment was present and that the miner did not suffer from pneumoconiosis. Claimant's lung function was normal, and was, at most, minimally impaired. Any impairment suffered by the miner could not relate to coal mine employment, but any disability was owing to obesity and heart disease. Dr. Morgan issued a supplemental report on July 29, 2004. (EX 4). Dr. Morgan opined that obesity caused the miner's abnormal x-ray, not asbestos exposure. The x-rays did not provide any evidence of pneumoconiosis. Claimant's total disability was due to obesity, and his respiratory impairment was due to obesity. Dr. Morgan does state that certainly coal dust exposure could not be the cause of the miner's respiratory problems.

Hospitalization records

The miner was hospitalized from December 27 to December 31, 1996, and on March 11, 1997. Claimant's 1996 hospitalization was primarily due to acute exacerbation with bronchitis of chronic obstructive pulmonary disease and pneumoconiosis. (CX 1). Claimant's secondary

[4] To some extent, Dr. Jarboe's opinion relies on a two and a half pack a day smoking history that was clarified as a typographical error in Dr. Rasmussen's 1997 report.

diagnosis was pneumoconiosis. The miner admitted with breathing difficulty and a history was listed as 'known' pneumoconiosis and 'longstanding' chronic obstructive pulmonary disease. During the physical exam, wheezing and rhonchi were noted as well as poor air exchange. Diagnostic testing revealed no infiltrates in the lung fields. On March 11, 1997 Claimant presented to the emergency room with shortness of breath and thick sputum production. A history of chronic obstructive pulmonary disease, emphysema and black lung disease were noted. The miner's x-ray was negative for infiltrates and the EKG was negative for ischemia.

Conclusions of Law

Benefits are provided to miners who are totally disabled due to pneumoconiosis. § 718.204(a). Claimant has the burden of proving by a preponderance of the evidence that he has pneumoconiosis arising out of coal mine employment and that he is totally disabled as a result. *Gee v. W.G. Moore & Sons, Inc.,* 9 B.L.R. 1-4 (1986). Benefits are provided under the Act if the evidence establishes that the miner: 1) suffers from pneumoconiosis; 2) that such pneumoconiosis arose out of coal mine employment; 3) that the miner is totally disabled; and 4) the pneumoconiosis contributes to the total disability. § 725.202(d)(2) (2001). The failure to establish any of these four elements results in a denial of benefits. *Hall v. Director, OWCP*, 2 B.L.R. 1-998 (1980).

Motion to Strike

Employer filed a Motion to Strike on September 9, 2004 regarding the x-ray film dated August 4, 1998 based on documentation that proved the film was destroyed in 2003 by the Radiology Department of Princeton Community Hospital. The employer has a due process right to inspect all relevant evidence. See *Kislak v. Rochester & Pittsburgh Coal Co*., 2 B.L.R. 1-249, 1-258 to -259 (1979). However, regarding interpretations of x-ray evidence of the opposing party, due process may be satisfied either by examination of the original x-ray film or by cross-examination of the interpreting physician. *Pulliam v. Drummond Coal Co.*, 7 B.L.R. 1-846, 1-848 (1985). The employer did not establish that both the x-ray film and the interpreting physician are unavailable for examination. Therefore, the Employer's Motion to Strike is denied.

Responsible operator and length of employment

I find that the Claimant's testimony and Social Security records establish twenty-six years of coal mine employment.

The district director has the burden to investigate and assess liability against the proper operator. *England v. Island Creek Coal Co*, 17 B.L.R. 1-141, 1-444 (1993). However, if the operator is financially incapable of assuming liability, the ruling in *Director, OWCP v. Trace Fork Coal Co. [Matney]*, 67 F. 3d 503 (4th Cir. 1995), *rev'g. in part sub. nom.*, 17 B.L.R. 1-145 (1993), allows the district director to reach back and name earlier operators. In this case, the district director determined after investigation that Sewell Mining Associates and its general partners, Richard McDorman and McDorman Mining, Inc., (hereinafter Sewell) would be potential responsible operators due to the miner's employment with the company for excess of

one year. The uncertain ability of Sewell to assume financial responsibility for this miner's claim resulted in the district director naming Amigo Smokeless Coal Company (hereinafter Amigo) as a potential responsible operator in this claim.

The district director is charged with the responsibility of investigating the responsible operator issues and designating which employers are potential responsible operators. The miner's Social Security records establish five potential responsible operators that employed the miner for a cumulative period that equals one year and whom otherwise presumably meets the requirements of §§725.492 and 725.493: Winding Gulf, V&R Coal Company, E&A Coal Company, Sewell, and Amigo. The miner was employed at Winding Gulf between 1967 and 1970; Amigo between 1966 and 1976; V&R from 1974 to 1978; Sewell from 1981 until 1983; and E&A from 1979 to 1980 and between 1988 and 1992. When determining liability between two or more operators, the responsible operator is the operator who satisfies the criteria of § 725.492 (2000) and 725.495 (2001) and had employed the miner most recently for a cumulative period of one year and has not demonstrated an inability to pay benefits. See §§ 725.492 (2000) and 725.495 (2001).

E&A was the most recent operator to employ the miner for the prescribed period. The district director dismissed E&A from potential liability as a responsible operator due to its inability to pay the miner's benefits. Specifically, E&A was dismissed because of its lack of insurance and the miner's status as a principal operator in the company. The district director erred in dismissing E&A as a potential responsible operator. The miner's status as a principal operator in E&A does not, absent other facts, preclude E&A from becoming a proper responsible operator. Additionally, the district director's finding that E&A was not insured does not satisfy the inability to pay requirement. Issues such as bond coverage, self-insurance, or the existence of assets sufficient to secure payment would need to be resolved before a potential responsible operator would be deemed unable to pay. As such, the record does not support the dismissal of E&A as a potential responsible operator.

Sewell and Sewell's general partners were named as potential operators. Sewell is the next operator that employed the miner for a cumulative period in excess of one year. The miner's employment with Sewell satisfies all the requirements of § 725.492(a)(1-3). The district director investigated Sewell and Sewell's general partners. The record reveals that Sewell and Richard McDorman, general partner, filed for and received bankruptcy protection, and that McDorman Mining, general partner, also had received bankruptcy protection.[5] The district director's conclusion that Sewell's failure to cooperate with the investigation precluded Sewell from being dismissed as a responsible operator is supported by the lack of evidence regarding whether each named party in connection with Sewell has bond coverage, self-insurance, or the existence of assets sufficient to secure payment. Each named party in connection with Sewell has received bankruptcy protection, but this fact alone does equate to a finding that Sewell and Sewell's general partners are unable to pay under § 725.492(a)(4). Therefore, Sewell and the Sewell general partners are properly named as potential responsible operators.

[5] Sewell and Richard McDorman's bankruptcy records were included in the district director's exhibits, and Richard McDorman interrogatories provide that McDorman Mining was also bankrupt. See DX 68.

Amigo is the third potential responsible operator which satisfies the requirements in 725.492(a)(1-3). No evidence suggests that Amigo would be unable to assume the payment of benefits due to its status as self-insured, thereby satisfying § 725.492(a)(4). Therefore, Amigo is also properly designated as a potential responsible operator in this claim. Amigo's satisfaction of the regulatory requirements and its ability to pay benefits negates any further investigation of later potential responsible operators such as V&R and Winding Gulf.

The West Virginia Coal Workers Pneumoconiosis Fund is also a possible party of interest to this case due to their coverage of successful claims made against bankrupt operators. Therefore, the Fund should have been named as a party in interest to this litigation.

In sum, insufficient evidence of record exists to dismiss E&A as a potential responsible operator in this claim. However, the district director limited the potential liability for this miner to Sewell and Amigo. Sewell, both as an entity and its general partners, shall be dismissed as potential responsible operators in this case due to the absence of evidence showing ability to pay based on bonds, self-insurance or assets. The district director possesses the duty to develop these items of evidence, and the district director's finding that it was impossible to name the correct responsible operator due to the complexity of this case was not accurate. The absence of evidence that shows the ability to pay is the benchmark for identifying the proper responsible operator in this claim. Clearly, Amigo satisfies all elements for designation, and evidence is insufficient to establish Sewell, as an entity or its general partners, or E&A as the properly designated responsible operator. Therefore, Amigo is the properly designated responsible operator for this claim because it is the only operator that clearly satisfies the requirements under § 725.492(a)(1-4).

Existence of pneumoconiosis

A finding of the existence of pneumoconiosis may be based on chest x-rays, autopsies or biopsies, the presumption in §§ 718.304, 718.305 or 718.306, and the reasoned medical opinion of a physician that the miner has pneumoconiosis as defined in § 718.202 (a)(1)-(4).

The regulations define pneumoconiosis broadly as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. § 718.201. This definition includes not only medical, or "clinical," pneumoconiosis but also statutory, or "legal," pneumoconiosis. *Id.* Legal pneumoconiosis includes "any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." *Id.*

There are eight chest x-ray films in the record, which have collectively been interpreted twenty-two times. Only three interpretations found the existence of pneumoconiosis: the film dated March 20, 1998 was read by Dr. Ranavaya as 1/0, p/q; the film dated August 26, 1998 was read by Dr. Jabour as 1/1, p/p; and the film dated April 29, 1998 was read as 1/1, p/p by Dr. Ranavaya. The other nineteen interpretations made primarily by board-certified radiologist b-readers found no evidence of pneumoconiosis, and these interpretations included the most

recent films taken in December of 1999. The x-ray evidence fails to establish pneumoconiosis by a preponderance of the evidence.

There is no biopsy evidence and the enumerated presumptions are not applicable to this claim. The record contains the medical opinions of eight physicians. Three physicians found that the miner suffered from pneumoconiosis. Dr. Rasmussen examined Claimant twice. He diagnosed clinical pneumoconiosis based on coal dust exposure history and a 0/1 t/p x-ray in 1996. In 1997 he diagnosed legal pneumoconiosis by finding the miner suffered from chronic obstructive pulmonary disease caused by smoking and coal dust exposure, which was based on ventilatory studies. Dr. Ranavaya diagnosed clinical pneumoconiosis in 1998 based on a 1/0, p/s x-ray and coal dust exposure history. Dr. Jabour found that the miner suffered from legal pneumoconiosis in the form of a moderately severe obstructive lung disease with air trapping caused in part by coal dust exposure.

Dr. Castle found some pleural thickening which was not consistent with pneumoconiosis, but was either subpleural fat or asbestosis. Dr. Castle opined that the miner suffered from asthmatic bronchitis which was smoking induced. Dr. Fino found that the miner did not suffer from pneumoconiosis or any other respiratory impairment and any pleural thickening was unrelated to coal dust exposure or coal mine employment. His opinion was based on the majority of x-ray interpretations being read as negative for pneumoconiosis, his own x-ray interpretations, and the lack of ventilatory impairment evidenced by pulmonary function studies or blood gas studies. Dr. Loudon reviewed the record and found the miner suffered from a reversible chronic airflow obstruction, which was inconsistent with impairments caused by coal dust exposure or pneumoconiosis. Dr. Loudon found that Claimant suffered from a minimal to mild airflow obstruction which was compatible with obesity and smoking. Dr. Jarboe reviewed the record and found that the objective evidence was insufficient to support a diagnosis of pneumoconiosis, but a diagnosis of bronchial asthma was supported by the miner's improved pulmonary function studies, the miner's reports of environmental irritants causing greater distress, and the variations over time in pulmonary function. Finally, Dr. Morgan reviewed the record and found that the miner did not suffer from pneumoconiosis or any pulmonary impairment, but that any disability suffered by the miner or any abnormality on the miner's x-rays were caused by the miner's obesity.

The medical reports of Drs. Castle and Loudon are well reasoned, well documented, and based on extensive information. See *Church v. Eastern Assoc. Coal Co.,* 20 B.L.R. 1-8 (1996) (opinion based on more extensive information is more probative). Dr. Castle had several reports that span six years of the miner's medical history which are well documented and explained. Dr. Loudon and Dr. Jarboe both diagnosed forms of chronic obstructive pulmonary disease, but adequately supported their diagnoses with objective medical evidence and provided a rationale for ruling out coal dust exposure as a viable cause of the miner's impairments. Dr. Jarboe's reliance on an incorrect smoking history will result in his report receiving less weight, but his diagnosis of bronchial asthma was also based on reports of environment irritation which, although inconsistent with Dr. Rasmussen's report, is not internally inconsistent with Dr. Jarboe's findings or dependent upon the smoking history of the miner. Dr. Fino opined that the miner did not suffer from pneumoconiosis or a respiratory impairment, and that the miner was not disabled. Dr. Fino's conclusions are against the weight of the evidence and his opinion rests

primarily on the invalidation of pulmonary function studies, which otherwise qualify as disabling. Dr. Fino's provides no rationale or documentation to support his opinion regarding the invalidity of the testing, and as a result his opinion will be afforded no weight. Dr. Morgan opined that obesity caused the miner's abnormal x-ray and the x-rays did not provide any evidence of pneumoconiosis. Dr. Morgan further opined that the miner suffered, at most, from a mild pulmonary impairment that was caused by obesity. Dr. Morgan failed to provide a well reasoned rationale for this conclusion, and did not discuss how the miner's extensive coal dust exposure history was ruled out as a contributing cause of any pulmonary impairment. An unsupported medical conclusion is not a reasoned diagnosis, and therefore Dr. Morgan's report will be given less weight. See *Duke v. Director, OWCP,* 6 B.L.R. 1-673 (1983).

Dr. Jabour diagnosed legal pneumoconiosis and his opinion was well reasoned, however he failed to provide documentation of the underlying testing performed during his examination of the miner and therefore his opinion will be afforded less weight. Dr. Ranavaya relied on x-ray evidence to support his diagnosis of pneumoconiosis and his x-ray reading was clearly against the weight of the evidence. Dr. Ranavaya's report therefore will be afforded less weight, although his reliance on coal dust exposure history to support his diagnosis will still be considered. Dr. Rasmussen relied in part on x-ray interpretations for his first diagnosis of clinical pneumoconiosis, which was against the weight of the x-ray evidence. However, Dr. Rasmussen's diagnosis of legal pneumoconiosis in 1997 was well reasoned and documented. Therefore, Dr. Rasmussen's diagnosis of legal pneumoconiosis will be given greater weight and his diagnosis of clinical pneumoconiosis based on x-ray evidence will be afforded less weight.

The medical reports fail to establish that the miner suffered from pneumoconiosis. Drs. Castle, Loudon, and Jarboe provided well-reasoned and well-documented medical reports which were based on extensive objective evidence. None of these doctors found sufficient evidence to diagnosis pneumoconiosis and all of these doctors found the miner's pulmonary impairment to be due to causes other than coal dust exposure. The physicians provided well reasoned rationales for their findings. Dr. Rasmussen's diagnosis of legal pneumoconiosis was likewise compelling, but alone fails to prove pneumoconiosis by a preponderance of the medical reports.

Taken as a whole, the medical reports and chest x-ray evidence fail to establish that the miner suffers from pneumoconiosis by a preponderance of the evidence. *See Island Creek Coal Co. v. Compton,* 211 F.3d 203 (4th Cir. 2000).

Existence of total disability

A miner shall be considered totally disabled if the irrebuttable presumption in § 718.304 applies. If that presumption does not apply, a miner shall be considered totally disabled if his pulmonary or respiratory impairment, standing alone, prevents him from performing his usual coal mine work and comparable and gainful work. § 718.204(b)(1). In the absence of contrary probative evidence, a miner's total disability shall be established by pulmonary function studies showing values equal to or less than those in Appendix B, blood gas studies showing the values in Appendix C, the existence of cor pulmonale with right sided congestive heart failure, or the reasoned and documented opinion of a physician finding that the miner's pulmonary or

respiratory impairment prevents him from engaging in his usual coal mine work and comparable and gainful work. § 718.204(b)(2).

The finding of Claimant's total disability is based on the medical evidence of record. The record contains seven pulmonary function studies, of which five produced qualifying values.[6] The four blood gas studies produced one qualifying test and three non-qualifying tests. There is no evidence that the miner has cor pulmonale.

The record contains eight medical opinions. Dr. Rasmussen found the miner to be unable to perform his last coal mine employment, which required heavy labor, due to his significant loss of lung function. Dr. Ranavaya found a moderate pulmonary impairment which would prevent Claimant from performing his last coal mine employment based on ventilatory studies. Dr. Jabour found the miner to suffer a twenty percent pulmonary disability, but also opined that the miner was unable to perform his last coal mine job due to his respiratory impairments. Dr. Fino found that the miner did not suffer from a respiratory disability, but this opinion was based on the invalidation of testing, which as previously discussed will be afforded no weight. Dr. Castle found the miner retained the capacity to perform his last coal mine employment, after diagnosing a mild pulmonary impairment. Dr. Loudon found that the miner had a mild pulmonary impairment but then stated he was totally disabled but not due to a limited amount of reversible chronic airway obstruction. Dr. Loudon does state that the miner would be unable to perform his last coal mine employment but fails to state the basis for this conclusion, although he does state it is not due to the respiratory diagnosis. Dr. Loudon's opinion regarding total disability is equivocal, and will be afforded no weight. Dr. Jarboe found that the miner retained the functional capacity to perform his last coal mine employment in a "dust free environment." This determination will be interpreted as a finding that the miner is capable of performing comparable and gainful work. Finally, Dr. Morgan stated that the miner suffered, at most, from a lung function which is minimally impaired. Dr. Morgan opined that the miner could in fact be totally disabled, but this is due to a list of conditions that are not respiratory in nature, such as obesity. However, Dr. Morgan failed to discuss whether the miner was capable of performing his last coal mine employment from a pulmonary standpoint, and as such his opinion as to total disability will be afforded less weight due to its equivocal nature.

The miner has shown by a preponderance of the evidence that he is totally disabled from a pulmonary standpoint due to the majority of qualifying pulmonary function studies. Although some physicians discussed the shortcomings of the miner's prior pulmonary function studies, none of these discussions dismissed all qualifying tests nor provided a compelling basis to disregard all four qualifying tests. Therefore, I find that Claimant is totally disabled. Additionally, the medical opinions of record support a finding of total disability as the majority of the well-reasoned and well-documented opinions find that the miner is unable to perform his last coal mine employment due to his pulmonary impairment.

However, because the miner has failed to establish that he suffers from pneumoconiosis, the miner's total disability cannot be due to pneumoconiosis. Therefore, I find that Claimant is not totally disabled due to pneumoconiosis.

[6] The pulmonary function studies dated 5/14/96; 9/3/96; 8/11/97; 3/20/98; and 12/21/99 produced qualifying results while tests dated 4/20/98 and 8/26/98 did not produce qualifying values.

ORDER

IT IS ORDERED THAT the claim of Aaron D. Bolen is DENIED.

A

DANIEL L. LELAND
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601***. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.